Understanding How Insurance Works

move . play . grow

Insurance has become a very confusing process in today's healthcare environment. We hope that our resource guide will help you better understand some common areas of confusion and help you navigate the process. We have put together a "question and answer" guide based on our experience to streamline tips and strategies that may be relevant to you.

Disclaimer: The following is for general informational purposes only and is not, and should not be construed as legal, financial or insurance health advice. Health insurance benefits and coverage is a constanty changing area and availability and application of benefits varies from plan to plan and from policy to policy based on individual circumstances. POTS assumes no responibility for the outcome of any coverage decision or any denial of benefits.

1. **What is the difference between a "deductible" and an "out-of-pocket maximum"?**

   A deductible is a dollar amount that a subscriber is required to spend before their insurance carrier will begin contributing their portion of the coverage/coinsurance. Please keep in mind that your "deductible" does not necessarily apply to every type of service benefit, therefore when verifying benefits always ask if the deductible applies to each service.

   The **out of-pocket** maximum is the most you will have to pay for covered services in a given plan year. Once you have met the out of pocket maximum through deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.

2. **What is the difference between a "copay" and "co-insurance"?**

   - **The co-pay** is a specific amount of money that you spend on an office visit. A copay is typically paid at the time of your visit and is a flat amount, such as a $40.00.
   - **Co-insurance** is when insurance covers a percentage of the charges and the insurance subscriber pays the remaining percentage. Thus the costs are shared by the the insurance subscriber and the insurance provider. Typically, specialty services such as Occupational Therapy are subject to co-insurance instead of a co-pay.

     For example: Your benefit covers 60% of the fee for Occupational Therapy for a maximum of 12 visits in a calendar year. You are responsible for 40% of the expense for 12 visits and then 100% for all O.T. services after 12 visits, unless additional visits are authorized.

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3. **How likely am I to get approved for additional visits beyond the initial visit allotment?**

   Typically, insurance carriers will authorize an initial allotment (e.g. 12 visits of OT, PT, SLP combined). However, they may state that more visits may be approved based on "medical necessity." This can often be misleading as we find that clients anticipate that insurance will cover many additional sessions. However we find that typically once you reach the initial allotment threshold, fewer and fewer additional visits are authorized. For example, when submitting for approval beyond the initial visit maximum cap, we frecuently see that 3-4 visits may be approved and then a medical review will be requested when each allotment is exhausted. This triggers the combersome process of submitting clinical documentation, case management review, and potentially additional steps such as "peer to peer" review. It is important to understand that each of these additional steps take time. You should be prepared that not all sessions, necessary to ensure continuity of care therapy, will be covered by insurance. There may be interuptions in coverage during this process that you will be financially responsable for.

4. **If my insurance requires POTS to request for "pre-authorization," is there an additional charge?**

   POTS does not charge for submitting requests for "pre-authorization", however if the process demands more than 30 minutes of administrative time, POTS will ask you to follow up with your insurance carrier on your own, or you may request additional administration time from POTS for a fee.

5. **Does POTS submit to my insurance if I am accessing my out-of-network benefits?**

   POTS has the ability to submit claims to your insurance in an attempt to access out-of-network benefits. If your out-of-network benefit does not reach a minimum threshold determined by POTS, then we will bill you for services at a discounted prompt pay rate. For promt pay patients, POTS does not submit claims, get authorizations or communicate at all with your insurance carrier. Feel free to submit on your own. There are no guarantees of coverage.

6. **What is a "GAP exception"?**

   A network gap exception is a tool that health insurance providers use to bridge the gap in their network of contracted healthcare providers. This may enable insurance subscribers to access "in-network benefits" from an out-of-network service provider like POTS. Each company's gap exception has its own set of rules. POTS does not accept all in-network gap exceptions.

7. **How can I maximize my chances of insurance covering therapy?**

   - Take time to understand your plan benefits, the claims process, exclusions, and diagnoses that are not covered.

   - Get a prescription or doctor's order from your pediatrician or referring physician. The doctor's order should state: your child's name, date of birth, diagnosis, diagnosis code(s) and prescribe

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"Occupational (Physical or Speech Therapy or Feeding) therapy evaluation and treatment." A doctor's prescription/order helps to support the medical necessity of the services regardless of wether the insurance requires a doctor's order.

- Submitting a copy of your Occupational, Physical & Speech Therapy Evaluation when submitting claims can help support the overall process.

- Submitting claims within 7 days from your "date of service" and following up with insurance within 14 days of your claim submission. Timeliness is essential when managing the claims submission process.

- Ensure that you download your superbill within 7 days each time you receive it, or it will no longer be available, as per HIPAA regulations. Save all bills.

- Create an insurance tracking spreadsheet to keep track of claims submitted, claims denied and claims paid.

- Scrutinize and keep all of your "Explanation Of Benefits" and call the insurance company with questions and concerns.

8. What do I do if I have an Occupational, Physical, or Speech Therapy benefit, the verification of benefits indicates that I am not subject to any exclusions, and I submitted the claims appropriately, but coverage is denied?

Unfortunately, it is extremely common to have claims denied even when a client appears to have coverage and has completed the process correctly. In our experience, we have seen two identical claims submitted. One claim was denied, and one was covered, and there is no justification for the denial. The bottom line is that follow up is essential. Here are some tips:

- Call your insurance company to determine the reason for denial. Ask for a copy of the plan's benefit policy for therapy and an explanation of the denial in writing if there is none on the explanation of benefits, or you don't understand it. Write down who you spoke to, the date and time, and what was said on each telephone call. Maintain all communication in a file.

- If you get health insurance through your employer, contact your Human Resources Department to see if the benefits department offers an insurance claim advocate to help you navigate the process. Request your child's pediatrician and referring physician to write letters of medical necessity to the insurance company in support of the need for therapy services.

- Make a formal appeal to your insurance company for reconsideration. Contact the Member Services Department to learn how to appeal insurance denials, obtain the mailing address

for the appeals department, and find out when to expect a response. Many insurance companies require that an appeal be submitted within 30 days of receiving the initial denial of the claim. Send all appeal documentation via certified mail and follow up with a phone call.

9. Are there financial resources available to support the overall expense of therapeutic intervention?

We are aware that the expenses for therapeutic intervention can add up and we also know that this investment in your child is priceless for his or her long-term health, wellness and success. With that being said, we know that every little bit counts and we have found that there may be additional "subsidies" that might help pay for therapeutic intervention. Here is a list of some subsidies that you can explore:

- **Flexible Spending Account "FSA":** This is a pre-tax benefit that many employers offer in which you can utilize pre-tax dollars that you put into your "FSA" for medical costs inclusive of therapy, dentist, healthcare, etc.
- **Health Savings Account "HSA":** This is a savings account often used in conjunction with a high-deductible that allows users to save money tax-free for medical expenses.
- **School Funding:** This is a increasingly more challenging to access. If your child qualifies for IEP funded services there are times where school funding can be utilized for an outside provider.
- **Social Security Disability Insurance (SSDI)** Social Security Disability Insurance is a financial benefit through Social Security. This payment is available for adults who have a disability that began prior to age 22. SSDI can be considered a "child's" benefit because it is paid on a parent's Social Security earnings record.
- **ABLE Accounts:** ABLE Accounts are tax-advantaged savings accounts for individuals with disabilities and their families. https://www.ablenrc.org/what-is-able/what-are-able-acounts/
- **Family Grant Opportunities:** https://www.autismspeaks.org/autism-grants-families
- **The United Way** can connect you with resources and services in your area, and answer questions about obtaining assistance. Call 2-1-1 or visit 211.org to learn about some of the options that might be available to you.
- **NeedHelpPayingBills.com** is a website which lists many sources of financial assistance.
- **USA.gov** maintains information on a variety of government assistance programs. In particular, see the page on Government Benefits, Grants, and Loans.
- **The Patient Advocate Foundation** is a good place to search for grants and other forms of financial assistance, particularly if someone in your family has a medical condition. You can search for resources based on medical diagnosis. http://www.patientadvocate.org

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